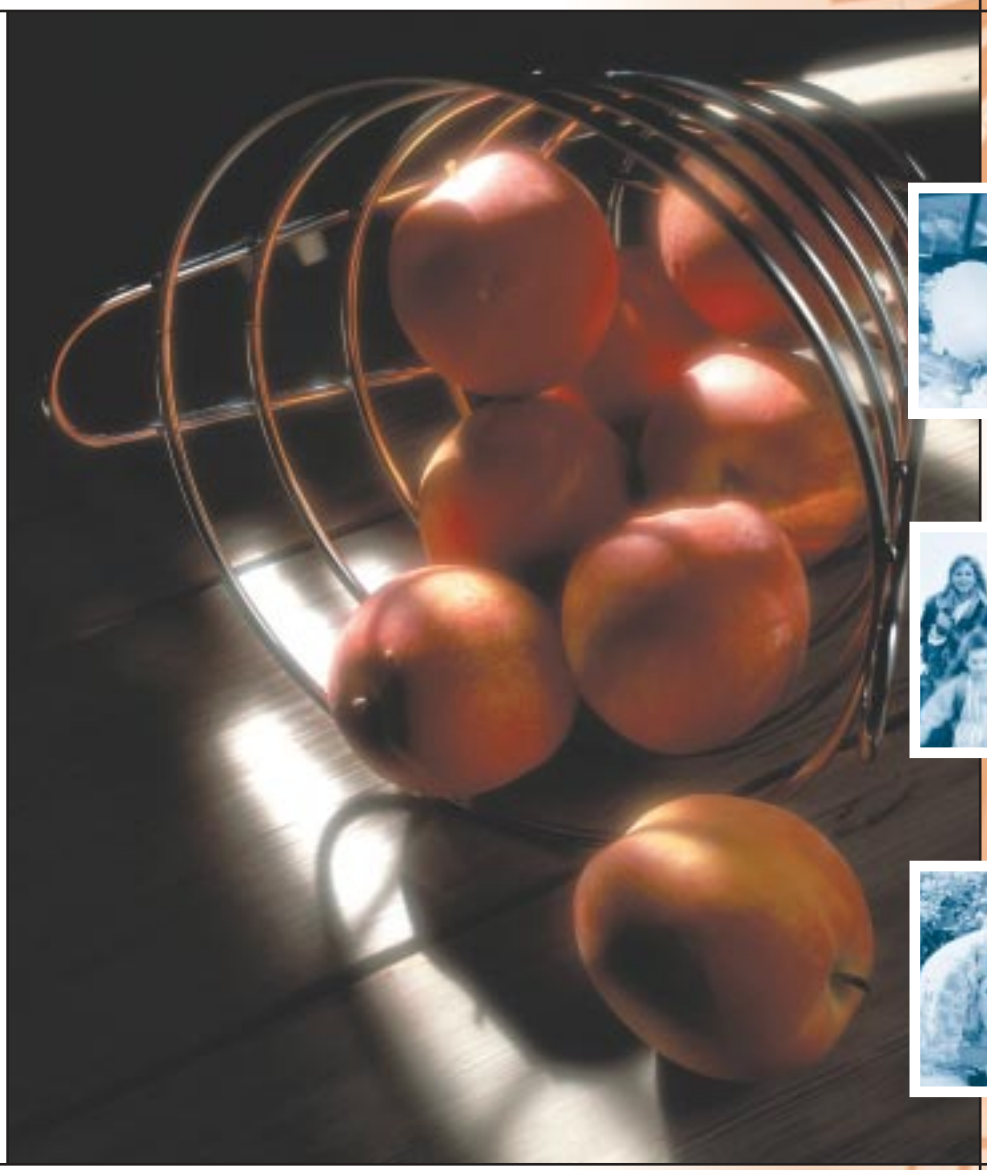
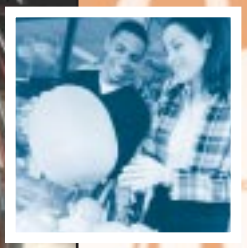
Georgia Department of
Community Health
Division of Public
Employee Health Benefits





STATE HEALTH BENEFIT PLAN

HEALTH PLAN DECISION GUIDE

JULY 1, 2002 – JUNE 30, 2003

PREFERRED PROVIDER ORGANIZATION (PPO) OPTIONS

INDEMNITY OPTION

HEALTH MAINTENANCE ORGANIZATION (HMO) OPTIONS

PHONE NUMBERS AND CONTACTS FOR BENEFIT AND PROVIDER INFORMATION

Georgia Department of Community Health
Open Enrollment Period for 2002 – 2003
April 15 – May 14, 2002

Check www.statehealth.org to make coverage changes online during Open Enrollment—or www.gabenefits.org if you participate in the Flexible Benefits Program.

Benefit and Rate Information

PPO Option and PPO Choice Option

- For rate information, contact your personnel/payroll representative
- For benefit coverage information, call Member Services at:

  (800) 483-6983 (outside Atlanta), or (404) 233-4479 (in Atlanta)

TDD line for the hearing impaired: (404) 842-8073

During the Open Enrollment Period, call volume for these numbers is expected to be very high, and you may experience time on hold.

You can get both National and Georgia PPO provider information online at: www.healthygeorgia.com

HMOs

BlueChoice Healthcare Plan
(800) 464-1367
Online provider information: www.bcbsga.com

CIGNA HealthCare of Georgia
(800) 564-7642
Online provider information: www.cigna.com

Kaiser Permanente
(404) 261-2590
(800) 611-1811
Online provider information: www.kp.org/ga

UnitedHealthcare of Georgia
(866) 527-9599
Online provider information: www.provider.uhc.com/gdch

Indemnity Option (Formerly Named High Option)

- For rate information, contact your personnel/payroll representative
- For benefit coverage information, call Member Services at:

  (800) 483-6983 (outside Atlanta), or (404) 233-4479 (in Atlanta)

TDD line for the hearing impaired: (404) 842-8073

Prescription Drug Program Information

PPO, PPO Choice, and Indemnity Options

Contact the Pharmacy Benefits Manager, Express Scripts, at (877) 650-9342

The information regarding Plan changes on page 4 of this Guide constitutes official notification to State Health Benefit Plan (SHBP) members of Plan changes and, as such, supersedes any previously published information that conflicts with the material included in this section of the Guide. Please keep this Guide with your Plan documents for future reference. It will be used in conjunction with the SHBP booklet dated November 1, 1995, the HMO Member Handbook dated March 1998, plus any *UPDATER* published after November 1, 1995,* to administer the Plan until new booklets are published. If you are disabled and need this information in an alternative format, call TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 38342, Atlanta, GA 30334.

* This is the fourteenth official Plan update published since the SHBP booklet dated November 1, 1995.

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Making Informed Health Plan Coverage Decisions

The Georgia Department of Community Health, which administers the State Health Benefit Plan (SHBP), continually seeks to bring you high-quality, affordable health coverage. Keep in mind, however, that you are the manager of your health care needs, and in turn, must take the time to understand your Plan benefit choices in order to make the best decisions for you and your family. During the Open Enrollment Period or if you are a new employee, it is important that you carefully review the coverage option information provided in this *Health Plan Decision Guide*. You should evaluate your health care needs and, if necessary, those of your dependents, as well as the premiums and out-of-pocket costs related to these different options before making your decision. Once you make your coverage decision, you may not make changes to your coverage outside the Open Enrollment Period unless you have a qualifying event under Section 125 of the Internal Revenue Code, which restricts changes in your SHBP elections during the Plan year.

If after reading this Guide you want more information before making a coverage decision, you can request a Summary Plan Description (SPD) booklet and *UPDATERs* from your personnel/payroll office. A new SPD will be available soon after the new Plan year begins.

Making informed decisions about your health care includes other considerations as well. Patient safety is a critical mission for the SHBP. Therefore, we offer these five steps to safer health care:

1. **Speak up if you have questions or concerns.** Choose a physician whom you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.

   - If you are considering PPO coverage, provider directories are available to help you choose physicians who have been credentialed in their specialties. Visit the MRN/Georgia 1st Web site at www.healthygeorgia.com for the most up-to-date listing of over 12,000 physicians and 170 hospitals in Georgia and a link to national PPO provider information for national access to 580,000 physicians and 3,400 hospitals. You also may visit your personnel/payroll office to review a listing of PPO providers.
   - If you are considering HMO coverage, provider directories are available from your personnel/payroll office. See the inside front cover for HMO Web sites that include provider information.

   However, the provider listings are subject to change without notice. Before selecting your physician, call the physician's office to make sure that physician is accepting new patients and that he/she is still a participating provider.

2. **Keep a list of all the medicines you take.** Tell your physician and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your physician ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. **Make sure you get the results of any test or procedure.** Ask your physician or nurse when and how you will get the results of tests or procedures. If you do not get them when expected—in person, on the phone, or in the mail—don't assume the results are fine. Call your physician and ask for them. Ask what the results mean for your care.

4. **Talk with your physician and health care team about your options if you need hospital care.**
   If you have more than one hospital to choose from, ask your physician which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.

5. **Make sure you understand what will happen if you need surgery.**
   Ask your physician and surgeon: "Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery?" Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your physician, and your surgeon all agree on exactly what will be done during the operation.

Making Open Enrollment Decisions

If you were hired after May 1, 2002, this year's Open Enrollment for health coverage does not apply to you. Please skip to page 6 on *Basic Plan Information for New Employees and Current Members.*

If you are a current SHBP member hired before May 1, 2002, you have the opportunity to make Health Plan changes during this Open Enrollment Period. The Open Enrollment Period for the 2002 – 2003 Plan year is April 15 through May 14. Coverage requested at that time takes effect on July 1, 2002.

Note: If you elect one of the HMO Options, receipt of your HMO card could be delayed if the HMO does not receive a primary care physician (PCP) selection. Be sure to select a PCP if you enroll online, or complete an *Enrollment Supplement for the Health Maintenance Organizations* form, available from your personnel/payroll office, to select your PCP. If you do not select a PCP, some HMOs will select one for you, based on where you live.

Exception: UnitedHealthcare does not require the selection of a PCP so you do not have to indicate one online or on the enrollment supplement form.

The following pages explain:

- What Plan changes are taking place on July 1, 2002 that may affect your benefits and/or the options you select;
- What happens if you do not make any coverage changes during Open Enrollment; and
- What you may want to consider before making an Open Enrollment coverage change.

What's Changing for 2002 – 2003

First, we have changed the names of two SHBP options for the next Plan year.

- What was formerly known as the High Option will now be called the **Indemnity Option.** This is more descriptive of the type of Plan offered.
- The Standard PPO Option will be called the **PPO Option.**

Effective July 1, 2002, other changes to your Plan options include:

- **For Indemnity Option members only:**

➤➤➤ An increase in the maximum out-of-pocket spending limit to $2,000 per person per Plan year with a $4,000 family maximum per Plan year.

- **For PPO Option members only:**

➤➤➤ A $20 co-payment for all outpatient therapy visits will be added, subject to the applicable deductible and co-insurance payments.

➤➤➤ Urgent care will be covered at 90% of the network rate, subject to the deductible, after a $35 co-payment.

- **For Indemnity and PPO Option members:**

➤➤➤ Coverage of specific osseous surgeries for the treatment of periodontal disease is an out-of-network benefit. Payment is subject to the maximum Allowed Amount under the Plan, with no Balance Billing. For the PPO Option, charges are subject to the out-of-network deductible.

➤➤➤ Blood products will be included as a covered inpatient/outpatient service.

➤➤➤ Orthognathic surgery for children age 19 and under, born with specific craniofacial syndromes, will be a covered service.

➤➤➤ Private room charges for isolation, when medically necessary, will be covered.

- Two new HMOs—CIGNA and UnitedHealthcare—will be available to you if you live or work in their service areas. A consumer choice option from each also will be available.
- Aetna U.S. Healthcare will not be available on or after July 1, 2002. **If you currently are in Aetna U.S. Healthcare and do not select another available option during the Open Enrollment Period, you will be transferred automatically to the PPO Option effective July 1, 2002.**

Effective July 1, 2002, you will be required to submit official documentation to verify dependent eligibility *when requested* by the Plan.

Official documentation includes copies of certified marriage licenses for spouses, and copies of certified birth certificates, court decrees, or adoption papers for children or stepchildren.

If verification cannot be made, the dependent's coverage will be terminated retroactively to his or her coverage effective date. The Plan will make every effort allowable under the law to recover any and all payments made by the Plan on behalf of an ineligible dependent. Please read the SPD and *UPDATERs* to review dependents eligible for coverage under the Plan. **To avoid reimbursing the Plan for claims paid on behalf of ineligible dependents, ineligible dependents should be removed from coverage during the 2002 – 2003 Open Enrollment Period.**

If You Do Not Make Any Changes During Open Enrollment

If you are a current Health Plan member hired before May 1, 2002, and you do not want to make any changes to your coverage, your current coverage option and type continues into the new Plan year. However, if you are an Aetna U.S. Healthcare HMO member and you do not select another available option during the Open Enrollment Period, your coverage will be transferred automatically to the PPO Option effective July 1, 2002.

It is not necessary to submit any paperwork if you do not want to make any changes or, for Aetna U.S. Healthcare HMO members, if you want PPO Option coverage effective July 1, 2002.

Reminder: *Please read the SPD and UPDATERs to review dependents eligible for coverage under the Plan.* ***To avoid reimbursing the Plan for claims paid on behalf of ineligible dependents, ineligible dependents should be deleted during the 2002-2003 Open Enrollment Period.***

If You Want to Change Your Coverage During Open Enrollment

The *Comparing Benefits Within Health Plan Options* section on page 13 of this Guide provides an overview of what services are covered by each option. Before choosing a new option, you'll probably want to look at the benefits offered and at physicians, hospitals, and other providers participating in the networks of the various options. For your reference, phone numbers for requesting provider directories and specific benefit information are listed on the inside front cover along with Web site addresses.

Knowing what your benefits cover can help prevent unexpected out-of-pocket expenses during the Plan year. Before you schedule a physician's appointment, for example, make sure you understand what services your new option covers. If you've chosen an option that offers a network of preferred providers, consider the difference between seeing in-network providers and out-of-network providers. Most out-of-network services will cost you more and are subject to balance billing.

During an Open Enrollment Period, the easiest and quickest way to enroll or make changes is online via the Internet. For online Open Enrollment transactions, there are two Web sites—one for employers that do not participate in the Flexible Benefits Program (FBP) offered through the Georgia Merit System (e.g., most local school systems and libraries) and one for other employers that do participate (e.g., most state agencies).

➤➤➤ **If you do not participate in the FBP (most school systems and libraries), visit www.statehealth.org. Using the security access code on your Membership Change Worksheet you receive from your personnel/payroll office, you can:**

- Change your address
- Change your coverage option
- Change your coverage type (Single/Family)
- Add or delete dependents
- Add or change primary care physicians for HMO Option selections
- Discontinue coverage

➤➤➤ **If you do participate in the FBP (most state agencies), visit www.gabenefits.org. After you follow the instructions and enter your selected personal security information, you can make the same changes described above (except an address change), and you can:**

- Enroll in the SHBP
- Enter selections related to other benefit programs offered in the FBP

If you do not have Internet access, enrollment forms are available at your personnel/payroll office. If you are eligible and select an HMO, you also must complete an *Enrollment Supplement for Health Maintenance Organizations* form from your personnel/payroll office, indicating your primary care physician.

Note: *If you sign up for one of the HMO Options, receipt of your HMO card could be delayed if the HMO does not receive your primary care physician (PCP) selection. Also, if you select UnitedHealthcare HMO, you do not need to select a PCP or complete the enrollment supplement form.*

REMEMBER THESE DEADLINES:

For enrolling or changing during the Open Enrollment Period — April 15 through May 14 — you can enter your changes on the Web sites or submit paperwork.

- www.statehealth.org
  8 a.m. (April 15) to 6 p.m. (May 14)
  Available 24 hours a day, 7 days a week.
- www.gabenefits.org
  7 a.m. (April 15) to midnight (May 14)
  Available 7 a.m. to midnight, 7 days a week.

After sending your changes online, **be sure to obtain a confirmation number. The confirmation number is your documentation that an online transaction occurred.** Please keep this confirmation number in a safe place.

➤➤➤ **If you do not need basic information on participating in the Plan, including information on who is eligible to participate, proceed to page 14 for a comparison of benefits.**

Basic Plan Information for New Employees and Current Members

If you were hired after May 1, 2002, or if you are a current SHBP member with basic questions about Plan participation, this section of the Guide is designed for you. More detailed information is available in the SPD and *UPDATERs,* that are available through your personnel/payroll office.

Who Is Eligible for Coverage

Coverage for You

You're eligible for Health Plan coverage through the SHBP if you meet certain eligibility requirements. These requirements are detailed in your SPD and *UPDATERs*.

Coverage for Your Dependents

A dependent is defined as:

- Your spouse, if you are legally married;
- Your never-married dependent children who are:
  1. Natural or legally adopted children and under age 19;
  2. Stepchildren under age 19 who live with you at least 180 days per year;
  3. Other children under age 19 if they live with you permanently and legally depend on you for financial support;
  4. Your natural children, legally adopted children, or stepchildren who were covered under the SHBP before age 19 and who are physically or mentally disabled and dependent on you for primary support (they may continue their existing Plan coverage past age 19); and
  5. Your children from categories 1, 2, or 3 above who are registered full-time students at fully accredited schools, are not employed full-time, and are between the ages of 19 and 25.

In order to cover a spouse or dependent under the Plan, you must provide documentation *upon request* from the Plan. The Plan requires:

- A copy of your certified marriage license to cover spouses;
- A copy of a certified birth certificate to cover a natural child;
- A copy of a stepchild's certified birth certificate, showing your legal spouse as the natural parent of the child, and a letter documenting that your stepchild lives in your home on a permanent basis in a parent-child relationship for at least 180 days per year;
- Adoption papers, guardian or court orders for other children who live with you permanently and legally depend on you for financial support. (The SHBP will recognize and honor a Qualified Medical Child Support Order (QMCSO) for eligible dependents. See your SPD for more information);
- Disability paperwork for disabled dependents 19 and over; this documentation must be received by the Plan before the child's 19th birthday; or
- A certification letter for full-time student dependents from the registrar's office of your child's school.

In any of these situations, you may be required to provide documents to verify your dependent relationships at Open Enrollment or at various periods throughout the Plan year.

How to Enroll Outside the Open Enrollment Period

If you're eligible to participate in the SHBP, you become a member by enrolling either:

- As a new hire, within 31 days of your hire date. If you join the SHBP during that first 31-day enrollment opportunity, your coverage will go into effect on the first day of the month after you complete one full calendar month of employment. See your personnel/payroll office for instructions on how to enroll.
- As a result of a qualifying event. See *Making Changes When You Have Qualifying Events* on page 8 of this Guide for more details.

If you do not enroll within 31 days of your hire date and you do not experience a qualifying event that would permit an enrollment, you will not have another opportunity to enroll until the subsequent Open Enrollment Period.

If you elect to decline SHBP coverage, you must complete a Declination Form, available from your personnel/payroll office, and file it within 31 days of your hire date.

If you decide to become an SHBP member, you will have two major choices to make:

- Your coverage option—PPO Option, PPO Choice Option, Indemnity Option, HMO Option, or HMO Choice Option (if you live or work in an HMO service area); and
- Your coverage type—Single or Family coverage. For details on Single and Family coverage, see your SPD and *UPDATERs*.

Keep in mind that once you do enroll or decline, you cannot change your coverage voluntarily until the next Open Enrollment Period, unless you experience a qualifying event that would permit a change.

Making Changes When You Have Qualifying Events

The benefit choices you make during Open Enrollment or as a new hire will stay in effect for the duration of the 2002 – 2003 Plan year, unless you experience certain changes in status as defined by federal law. Section 125 of the Internal Revenue Code, which governs the SHBP, does not permit canceling or otherwise changing your coverage during the Plan year unless you have a qualifying event.

Qualifying events include, but are not limited to:

- Marriage or divorce;
- Birth or adoption of a child or placement for adoption;
- Death of a spouse or child, if only dependent enrolled;
- Your spouse's or dependent's eligibility for or loss of eligibility for other group health coverage;
- A change in residence by you, your spouse, or dependents that makes you or a covered dependent ineligible for coverage in your selected option; and
- A change in employment status that leads to a loss or gain of eligibility under the Plan.

If you experience a qualifying event, you may be able to make changes for yourself and your dependents, provided you request those changes within 31 days of the qualifying event. For a complete description of qualifying events see your SPD and *UPDATERs*.

Special Enrollment Period

If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in the Plan, provided that you request enrollment within 31 days of when your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption, and provide the required documentation.

Overview of How Each Health Plan Option Works

On the following pages, you will find a brief description of each option and important considerations to help you select the best option for you. A comparison of specific benefits within each option is in the next section.

Contact the Member Services unit for each option if you need more detail. Telephone numbers are on the inside front cover. You also may request an SPD and *UPDATERs* to obtain more details on benefits and Plan participation.

To help you understand the information in this section, a few key terms are defined below:

Important Terms to Understand

Allowed Amount—A dollar amount the Plan uses to calculate benefits payable. The Plan uses the following Allowed Amounts:

1. Network Rate—for in-network PPO services;
2. Out-of-Network Rate—for out-of-network PPO services; and
3. Indemnity Rate—for Indemnity Option services.

Balance Billing—A dollar amount charged by a provider that is over the Plan's Allowed Amount for the care received. You are subject to balance billing when you receive services from non-participating providers, including emergency services.

Co-insurance Amount—The percentage of the Plan's Allowed Amount paid by a Plan member in the PPO or Indemnity Option. Depending on the option selected, the SHBP generally pays 90% to 60%, so your co-insurance is between 10% and 40%.

Co-payment—A set dollar amount that you pay at the time you receive services or items. For example, you pay a $20 co-payment for an in-network PPO physician's office visit while you are at the physician's office. You cannot be billed later for your co-payment. Co-payments do not apply to Plan year deductibles or out-of-pocket limits unless otherwise noted.

Deductible—A specified dollar amount, which varies by Plan Option, for specified covered services that you must pay out-of-pocket each Plan year before the PPO Option or Indemnity Option pays a benefit. Depending on your coverage option, the deductible may not apply to some services. For example, the deductible does not apply to in-network physician office visits under the PPO Option. HMO Options do not have deductibles.

Emergency Care—Care provided in the event of a sudden, severe and unexpected illness or injury which, if not treated immediately, could be life-threatening or result in permanent impairment of bodily function.

Lifetime Maximum—The most you and your covered dependents may receive in benefits from the SHBP during your lifetime(s) or while you and your covered dependents are Plan members.

Medical Certification Program (MCP)—A feature of the PPO and Indemnity Options that helps you and the Plan save money by preventing unnecessary care. To receive full benefits, you must comply with the MCP requirements outlined in the SPD and *UPDATERs*.

Out-of-Pocket Limit—A maximum amount you would have to pay out of your pocket each Plan year for covered services. Once you meet your out-of-pocket limit for the Plan year, the Plan pays 100% of the Allowed Amounts for most covered services for the rest of the Plan year. Your out-of-pocket costs for premiums, co-payments, and non-covered charges are **not** applied to the limit. The deductible is applied to your annual out-of-pocket limit.

Participating Provider—Any physician, hospital, or other health-services professional or facility that offers covered services and that has joined the PPO network, the Indemnity network, or HMO network for the Plan Option. Providers nominated and accepted under a Choice Option also are considered participating providers for the person making the nomination.

PPO Option

Anyone eligible for SHBP coverage may select the PPO Option.

The PPO Option consists of a network of over 12,000 Georgia participating physicians and 170 Georgia hospitals, over 580,000 physicians and 3,400 hospitals across the United States, and hundreds of ancillary providers that have agreed to provide quality medical care and services at discounted rates. You have the choice of using in-network or out-of-network providers. If you use in-network providers, you'll receive the highest level of benefits and avoid filing claims. To view the list of Georgia PPO providers online, visit www.healthygeorgia.com.

If you choose the PPO Option, you . . .

- Can access providers in the Plan's network of over 12,000 Georgia physicians and specialists and 170 hospitals to receive a higher level of benefit coverage.
- Do not need to select a primary care physician (PCP) or obtain referrals to see specialists.
- Pay less than the Indemnity Option.
- Have no balance billing when using participating PPO providers.
- Pay only a minimal co-payment for in-network PPO physician visits, prescription drugs, and some other covered services.
- May access any licensed out-of-network physician, specialist, or hospital at any time. However, you will generally pay more for out-of-network services and charges are subject to balance billing.
- Have maximum in-network coverage for age-appropriate preventive care, including coverage for office visits.
- Have coordinated care through a vast network of providers who will assist you in receiving the maximum level of benefits.
- May have a reduced pre-existing condition limitation if you can prove creditable coverage. See the HIPAA Annual Notice on page 35 of this Guide.

National PPO Network

As a PPO Option member, you have the added benefit of access to a national network of participating providers, which is managed by the Beech Street Corporation.

You can take advantage of this national network if:

- You or a dependent lives outside of Georgia;
- You have a dependent going to school in another state;
- You are traveling in another state; or
- You want to use an out-of-state provider.

The network consists of over 580,000 physicians and 3,400 hospitals across the United States. When you access Beech Street national providers outside the Georgia service area (see page 30), you are protected from Balance Billing. Your level of benefit coverage is generally different when using the national network and you are subject to separate deductibles. To view the list of national providers online, visit www.healthygeorgia.com. If you do not have Internet access, call Member Services for provider information.

Other Points to Consider

- You must call the Medical Certification Program (MCP) to precertify inpatient stays and specified outpatient procedures when you are using out-of-network providers or Beech Street providers.
- Some physicians affiliated with a PPO may not accept new patients at some times during the year. Check with the physician of your choice before you enroll in the PPO.

See *Comparison of Benefits: PPO Option and Indemnity Option* starting on page 14 for benefit details.

PPO Choice Option

Anyone eligible for SHBP coverage may select the PPO Choice Option.

PPO Choice Option benefits are the same as in the PPO Option. However, PPO Choice Option premiums are higher. In return for a higher premium, you can request that an out-of-network provider be reimbursed as an in-network provider. This request is known as a "nomination." If the out-of-network provider accepts your nomination, agrees to the PPO fees, and is approved by the PPO, you will receive in-network benefits from that provider. The in-network relationship between you and the provider remains in effect until either you or the provider terminates the agreement. You may nominate as many eligible providers as you wish at any time during the Plan year.

If your provider does not accept your nomination, does not accept the network fees, or is not approved by the PPO, then services from that provider are covered at the lower, out-of-network benefit level. SHBP rules do not permit a member to change options when a nominated provider or the PPO rejects a nomination.

Note that you may nominate only providers located and licensed in Georgia, even if you live out of state. After the PPO receives your nomination, the PPO has three business days to either reject or approve the nomination.

For further details regarding the nomination process and to obtain the necessary paperwork, please contact Member Services.

Note: The Behavioral Health Services (BHS) and transplant provider networks are separate from the PPO provider network. To nominate a BHS provider, contact the BHS Program at 800-631-9943. For nominations of transplant providers, call 800-762-4535 (outside Atlanta) or 770-438-9770 (inside Atlanta).

Indemnity Option
(Formerly Named High Option)

Anyone eligible for SHBP coverage may select the Indemnity Option.*

The Indemnity Option generally provides the same coverage level no matter which qualified medical provider you use. The Plan reimburses you for covered services, subject to the Plan's Allowed Amounts for covered services. Therefore, it is the most expensive Plan option.

The Indemnity Option has similar coverage levels when compared to in-network PPO benefits, but it has:

- A higher premium;
- Less coverage for preventive care; and
- No provider network outside of Georgia.

If you choose the Indemnity Option, you . . .

- Access any provider.
- Receive the same level of benefit coverage whether or not your provider is in the Indemnity network.
- Pay most health care bills up to the deductible amount **before** the Plan starts paying benefits.
- Continue to pay a percentage of the cost of covered expenses—co-insurance—after meeting the deductible (up to the out-of-pocket maximum) plus any non-covered costs or penalties.
- Are subject to Balance Billing in most cases.
- Receive the same level of coverage as offered in the PPO Option for prescription drug, behavioral, and transplant benefits. The Indemnity Option and PPO Option utilize the same provider networks for prescription drug, behavioral, and transplant benefits.
- Are not required to select a primary care physician (PCP) to get referrals to see specialists.
- May have a reduced pre-existing limitation if you can prove creditable coverage. See the HIPAA Annual Notice on page 35 of this Guide.

* Some contract groups that participate in the SHBP are not eligible to participate in the Indemnity Option.

Indemnity Option (continued)

Balance Billing

You may select any provider; however, some providers have agreed to accept discounted fees with no balance billing for the Indemnity Option. Amounts that are balance billed do not count toward your deductible or out-of-pocket spending limits.

Other Points to Consider

- The Indemnity Option is the most expensive option.
- The Indemnity Option does not include a national network of providers.
- Deductibles for office visits, medical care, and hospitalization must be met before benefits are payable.
- Coverage is available for preventive lab work and tests, subject to Allowed Amounts and annual maximums. Office visits for preventive care are covered, subject to the deductible and co-insurance. A co-payment-only benefit does not apply.
- Members must call the MCP to precertify in-patient stays at non-participating hospitals and members must precertify certain outpatient tests and procedures. Financial penalties apply if precertification rules are not followed.

HMO Options

HMO Options are available only to SHBP-eligible employees who live or work in an HMO's approved service area.* To see if you are eligible for an HMO, check pages 31-34 in this Guide. For the 2002 – 2003 Plan year, you may be eligible for up to four different HMOs.

HMOs provide prepaid benefits for most health care needs, with no bills or claim forms. You choose a primary care physician (PCP) from a list of providers. You must receive care from your PCP or from a physician or facility referred by your PCP for your expenses to be covered, except in cases of emergency and in other limited cases. If you receive care from a physician other than your PCP, or without being referred by your PCP, you won't receive any benefits coverage even if the physician or facility is in the HMO network.

Note: UnitedHealthcare HMO does not require you to select a PCP or obtain referrals to specialists.

If you choose an HMO Option, you . . .

- Must access physicians, specialists, and hospitals offered through the HMO's network to receive benefits, except for emergencies.
- Choose a primary care physician (PCP) to serve as your first point of contact for most health care services. Your covered family members also must select a PCP. PCPs refer you to network providers for specialty care.
- Pay only a minimal co-payment for HMO in-network physician visits, prescription drugs, and some other covered services.
- Have coordinated care through a network of HMO participating providers.
- Have low-cost access to the many services the HMO offers in preventive health care—well-baby and well-child care, physical exams, and immunizations.

* Some contract groups that participate in the SHBP are not eligible to participate in HMO Options.

Other Points to Consider

- Generally, you don't have to file claims.
- You pay the full cost for most non-referred services and for services received outside the HMO's network, except for emergencies.
- In most cases, HMOs do not have a deductible to meet—so your out-of-pocket costs may be lower.
- There are no pre-existing condition limitations.
- You may be required to follow the HMO's standardized treatment plan for your condition. For example, you may be required to receive treatment from your primary care physician for a specified period before being referred to a specialist.

HMO Choice Options

If you are eligible for an HMO Option, you also are eligible for that HMO's Choice Option.

HMO Choice Option benefits are the same as the respective regular HMO Option benefits. However, the Choice Option premiums are higher. In return for a higher premium, the HMO Choice Option gives members the opportunity to request that an out-of-network provider be treated as an HMO network provider. This request is known as a "nomination." You may nominate providers if they are located and licensed in Georgia and offer services the HMO covers. Also, you may nominate as many eligible providers as you wish at any time during the Plan year.

If the out-of-network provider accepts your nomination, accepts the HMO's fees, and is approved by the HMO, you may receive in-network benefits from that provider. If your provider does not accept your nomination, does not accept the HMO's fees, or does not get approved by the HMO, then services from that provider are not covered. SHBP rules do not permit a member to change options when a nominated provider or the HMO rejects a nomination.

Please contact the respective HMO directly to find out more about the required procedures and paperwork necessary to nominate a provider.

Comparing Benefits Within Health Plan Options

This section includes two charts, one that compares specific benefits within the PPO and Indemnity Options and one that compares HMO Option benefits. For more specific information on covered services, call the Member Services numbers listed on the inside front cover.

To make it easier to view information on the PPO and Indemnity Options, the chart is formatted in a "landscape" view.

SCHEDULE OF BENEFITS FOR YOU AND YOUR DEPENDENTS

July 1, 2002

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Maximum Lifetime Benefit (combined for Indemnity and PPO Option)	$2 million	$2 million		
Pre-existing Conditions; 1st year in Plan only, subject to HIPAA	$1,000	$1,000		
Lifetime Benefit Limit for Treatment of: (combined for Indemnity and PPO Option)				
• Temporomandibular joint dysfunction (TMJ)	$1,100	$1,100		
• Substance abuse	3 episodes	3 episodes		
• Organ and tissue transplants	$500,000	$500,000		
• Home hyperalimentation	$500,000	$500,000		
Deductibles/Co-payments:			In-Network/Out-of-State and Out-of-Network amounts combined	
• Deductible—individual	$300	$300	$400	
• Deductible—family maximum	$900	$900	$1,200	
• Hospital deductible/admission—excluding BHS and transplants	$100	Not applicable	Not applicable	Not applicable
• Hospital deductible/admission—BHS and transplants	$100	$100	$100	$100
• Emergency room co-payment	$60	$60	$60	$60
• Urgent care center co-payment	Not applicable	$35	$35	Not applicable

Annual Out-of-Pocket Maximums:			In-Network/Out-of-State and Out-of-Network amounts combined	
• Individual (you or one of your dependents)	$2,000	$1,000	$2,000	
• Family (you and your dependents)	$4,000	$2,000	$4,000	
• BHS program (per patient); BHS authorized care only	$2,500	$2,500		
Primary Care Physician or Specialist Office or Clinic Visits: • Treatment of illness or injury	90% of Indemnity Rate (IR); subject to deductible	100% of Network Rate (NR) after a per visit co-payment of $20; not subject to deductible	100% of Network Rate (NR) after a per visit co-payment of $20; not subject to deductible	60% of Out-of-Network Rate (OONR); subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/preventive health care • Well-newborn exam • Well-child exams and immunizations • Annual physicals • Annual gynecological exams Notes: Lab and test charges include such services as mammograms, prostate screenings/PSAs, and pap tests. Covered according to preventive care age schedules. Covered care schedules are online at www.healthygeorgia.com or call Member Services at (800) 483-6983 (outside Atlanta) or (404) 233-4479 (inside Atlanta).	90% of IR for office visit after deductible. 100% of IR with no deductible for associated lab and test charges, up to a maximum of $200 per person per Plan year; additional $125 benefit for screening mammogram.	100% of NR after $20 co-payment for office visit. 100% of NR with no co-payment for associated lab and test charges, up to a maximum of $500 per person per Plan year, including office visit charges (less the co-payment); maximum combined with In-Network/Out-of-State benefit.	100% of NR after $20 co-payment for office visit. 100% of NR with no co-payment for associated lab and test charges, up to a maximum of $500 per person per Plan year, including office visit charges (less the co-payment); maximum combined with In-Network/Georgia benefit.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.

COMPARISON OF PPO AND INDEMNITY OPTIONS

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Prescription Drugs Purchased at an Express Scripts network pharmacy, regardless of Health Plan option	$10 co-payment for generic drugs; $20 co-payment for preferred brand name drugs; 20% co-insurance for non-preferred brand name drugs, with a $35 minimum and $75 maximum co-payment. Co-payments for generic and preferred brand name drugs are applied to a monthly out-of-pocket maximum of $100 per person and $200 per family. When a member chooses a preferred brand name or non-preferred brand name drug over its generic equivalent, the member may be responsible for a higher co-payment than listed herein. Co-payments are based upon supplies of up to 30 days; some drugs are limited to a standard other than 30-day supplies. See the SPD and *UPDATERs* for details.			
Purchased at an out-of-network pharmacy, regardless of Health Plan Option	Member must pay full charges at point of sale and submit a paper claim. Members will be reimbursed at the pharmacy network rate less the required co-payment for covered drugs. Charges are subject to balance billing. Coverage provisions listed above also apply.			
Maternity Treatment (pre-natal and post-natal)	90% of IR; subject to deductible	90% of NR after an initial visit co-payment of $20; not subject to deductible	80% of NR after an initial visit co-payment of $20; not subject to deductible	60% of OONR; subject to deductible
Laboratory; X-Rays; Diagnostic Tests; Injections, including Medications Covered Under Medical Benefits—for the Treatment of an Illness or Injury	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Allergy Shots and Serum	90% of IR; subject to deductible	100% of NR; not subject to the deductible. If physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20.	100% of NR; not subject to the deductible. If physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20.	60% of OONR; subject to deductible
Allergy Testing	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible

Physician Services Furnished in a Hospital • Surgery in general, including charges by surgeon, anesthesiologist, pathologist, and radiologist	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
• Inpatient well-newborn exams	Not covered	100% of NR; not subject to deductible	100% of NR; not subject to deductible	Not covered
Physician Services That Are for Emergency Care	90% of IR; subject to deductible and to balance billing from non-participating providers	90% of NR; subject to deductible	90% of NR; subject to In-Network/Georgia deductible	90% of NR; subject to In-Network/Georgia deductible and to balance billing
Outpatient Surgery in the physician's office	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Outpatient Surgery—Hospital/Facility	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Hospital Services Other Than Those That Are for Emergency Care • Inpatient care, including inpatient short-term acute rehabilitation services	90% of IR; subject to a per admission deductible of $100	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
• Outpatient services — Non-emergency use of emergency room — Other	90% of IR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.	90% of NR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.	80% of NR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.	60% of OONR; subject to deductible. If services are in conjunction with non-emergency use of emergency room, benefit also subject to $60/visit co-payment.
• Well-newborn care	90% of IR; subject to a per admission deductible of $100	100% of NR; not subject to deductible	100% of NR; not subject to deductible	Not covered

COMPARISON OF PPO AND INDEMNITY OPTIONS

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Hospital Services That Are for Emergency Care • Treatment of an emergency medical condition or injury Notes: The $60 co-payment is reduced to $40 if referred by NurseCall 24 before receiving emergency room services.	90% of IR after a per visit co-payment of $60; co-insurance and hospital deductible, if admitted, apply. Subject to balance billing from non-participating providers.	90% of NR after a per visit co-payment of $60; co-insurance and deductible apply	90% of NR after a per visit co-payment of $60; co-insurance and In-Network/ Georgia deductible apply	90% of NR after a per visit co-payment of $60; co-insurance and In-Network/Georgia deductible apply. Subject to balance billing.
Ambulance Services for Emergency Care Notes: Limited to transportation for emergencies and benefits subject to balance billing from non-participating providers of ambulance services.	90% of IR; subject to deductible	90% of NR; subject to deductible	90% of NR; subject to In-Network/Georgia deductible	90% of NR; subject to In-Network/Georgia deductible
Urgent Care Services in an Approved Urgent Care Center	90% of IR; subject to deductible	90% of NR after a per visit co-payment of $35; subject to deductible	90% of NR after a per visit co-payment of $35; subject to deductible	Not applicable
Home Nursing Care Notes: Covers two hours of medically necessary skilled home care per day by RN or LPN if ordered by a physician; limited to $7,500 per Plan year. Member's share of cost is not applied to Plan year out-of-pocket limits.	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible

Hospice Care	100% of IR; subject to deductible and to hospital deductible, if in lieu of hospitalization	100% of NR; subject to deductible	100% of NR; subject to deductible	60% of OONR; subject to deductible
Durable Medical Equipment (DME)—Rental or Purchase	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services Notes: Coverage for up to 40 visits per Plan year when conditions are met for physical, speech and occupational therapies and for cardiac rehabilitation.	90% of IR; subject to deductible	90% of NR; subject to deductible and $20/visit co-payment	80% of NR; subject to deductible and $20/visit co-payment	60% of OONR; subject to deductible
Dental and Oral Care—Limited Coverage • Coverage in general Notes: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% of IR; subject to deductible and, if admitted, to hospital deductible	90% of NR; subject to deductible. Network providers may not be available for all covered services; charges are paid at 90% of NR, subject to balance billing.	80% of NR; subject to deductible. Network providers may not be available for all covered services; charges are paid at 80% of NR, subject to balance billing.	60% of OONR; subject to deductible
• Coverage of specific osseous surgeries for the treatment of periodontal disease Notes: Only out-of-network coverage available under Health Plan.	60% of OONR; subject to deductible, not subject to balance billing.	60% of OONR; subject to out-of-network deductible, not subject to balance billing.	60% of OONR; subject to out-of-network deductible, not subject to balance billing.	60% of OONR; subject to out-of-network deductible, not subject to balance billing.
• Temporomandibular joint syndrome (TMJ) Notes: Coverage only for diagnostic testing and non-surgical treatment of TMJ, up to $1,100 per person lifetime maximum benefit.	90% of IR; subject to deductible	90% of NR; subject to deductible	80% of NR; subject to deductible	60% of OONR; subject to deductible

COMPARISON OF PPO AND INDEMNITY OPTIONS

COVERED SERVICES	INDEMNITY OPTION *The Plan Pays:*	PPO OPTION In-Network/Georgia *The Plan Pays:*	PPO OPTION In-Network/Out-of-State *The Plan Pays:*	PPO OPTION Out-of-Network *The Plan Pays:*
Chiropractic Care Notes: Coverage for up to a maximum of 40 visits per Plan year.	90% of IR; subject to deductible	90% of NR; subject to deductible and $20/visit co-payment	80% of NR; subject to deductible and $20/visit co-payment	60% of OONR; subject to deductible
Behavioral Health Care With BHS authorization, regardless of Health Plan option	Inpatient hospital services for mental health and substance abuse are covered at 90% of network rate for up to a combined total of 60 days per person, per Plan year; associated professional fees are covered at 80% of network rate for up to 60 visits. Partial/day hospitalization is covered at 90% of network rate for up to 30 days/visits per Plan year. Outpatient professional services for mental health and substance abuse are covered at 80% of network rate for up to 50 visits per Plan year. Visit limitation includes up to three brief situational counseling sessions covered at 100% without deductible. All eligible charges are subject to deductibles ($300 PPO in-network/Georgia; $300 Indemnity Option deductible and $100 per confinement hospital deductible) and to a separate out-of-pocket limit of $2,500 per person, per Plan year. See the SPD and *UPDATERs* for full details on coverage provisions and exclusions.			
Without BHS authorization, regardless of Health Plan option	Inpatient hospital services for mental health and substance abuse are covered at 60% of the average network per diem rate when BHS-precertified for up to a combined total of 60 days per Plan year; associated professional fees are covered at 50% of the network rate for up to 25 visits per Plan year. Outpatient professional (MD/PhD) services for mental health and substance abuse are covered at 50% of the network rate for up to 25 visits per Plan year. All eligible charges are subject to deductibles and do not accumulate toward any out-of-pocket limit. Balance billing may apply. See the SPD and *UPDATERs* for full details on coverage provisions and exclusions.			
Transplant Services	The level of benefit coverage is based on whether or not you select a contracted transplant center, regardless of your Health Plan option. At contracted centers, the level of benefit coverage is 90% of the network rate for covered services. At non-contracted centers, the level of benefit coverage is 60% of the network rate for covered services.			

IMPORTANT CONSIDERATIONS

- Services covered under the PPO from an In-Network/Georgia provider will apply only to the In-Network/Georgia deductible and out-of-pocket limit.
- Services covered under the PPO from in-network/out-of-state and out-of-network providers apply to the same deductible and out-of-pocket limit.
- Lifetime benefit maximums are combined totals among the PPO Options, Indemnity Option, and HMO Options (except for Kaiser Permanente).
- Some PPO annual maximums and limitations are combined totals.
- Annual dollar and visit limitations, deductibles, and out-of-pocket spending limits are based on a July 1 to June 30 Plan year.
- Some services may require MCP precertification, prior approval, or letters of medical necessity before such services are covered by the Plan.
- Co-payments do not apply toward deductibles or out-of-pocket limits unless otherwise noted.
- Co-payments for a prescription drug may change at any time during the Plan year if the class of drug changes. For instance, if a preferred brand is reclassified as a generic, your co-payment would decrease. Also, if a preferred brand is reclassified as a non-preferred brand, your co-payment would increase. Consider this possibility if you participate in a Health Care Spending Account.
- PPO and Indemnity Options include a discount program for vision screenings and eyewear. Contact the BlueChoice Vision Program at (800) 377-6436 or visit www.bcbsga.com for more information. Vision Program availabilty is subject to change during the Plan year.
- See the SPD and *UPDATERs* for coverage details, including limitations and exclusions.

Comparison of Benefits: HMO Options

The following chart summarizes the benefits offered by the HMOs—BlueChoice, CIGNA, Kaiser Permanente, and UnitedHealthcare. Most covered services are the same for each HMO. If you are trying to choose among HMOs, you should:

- Check the service area covered by each HMO to see if you live or work in an approved county.
- Check which physicians, specialists, and hospitals are offered through the HMOs' networks. Would you have to switch physicians if you selected a new HMO? Are physicians' offices located near you? Phone numbers and Web sites for the HMOs are listed on the inside front cover.
- Compare covered services and what your premium would be for each.

To help you compare all SHBP options, this HMO chart follows the same format as the PPO and Indemnity Option comparison of benefits.

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Maximum Lifetime Benefit	$2 million (all SHBP limits combined)	$2 million (all SHBP limits combined)	No lifetime benefit maximums	$2 million (all SHBP limits combined)
No Pre-existing Conditions 1st year in Plan only, subject to HIPAA.	None	None	None	None
Lifetime Benefit Limit for Treatment of: • Temporomandibular joint dysfunction (TMJ) • Substance abuse • Organ and tissue transplants • Home hyperalimentation	No separate lifetime benefit limit	No separate lifetime benefit limit	No lifetime benefit maximums	No separate lifetime benefit limit
Deductibles/Co-Payments: • Deductible—individual • Deductible—family maximum	Not applicable	Not applicable	Not applicable	Not applicable

continued... • Hospital co-payment/admission • Emergency room co-payment • Urgent care center co-payment	$200 $50 (waived if admitted) $15 with referral	$200 $50 (waived if admitted) $25	$200 $50 (waived if admitted) $30	$200 $50 (waived if admitted) $25
Annual Out-of-Pocket Maximums: • Individual (you or one of your dependents) • Family (you and your dependents)	Not applicable	Not applicable	Not applicable	Not applicable
Primary Care Physician or Specialist Office or Clinic Visits: • Treatment of illness or injury	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/preventive health care • Well-newborn exam • Well-child exams and immunizations • Annual physicals • Annual gynecological exams	100% after a per visit co-payment of $15 for primary care and $20 for specialty care	100% after a per visit co-payment of $15 for primary care and $20 for specialty care. No co-payment for immunizations and mammograms.	100% after a per visit co-payment of $15 for primary care and $20 for specialty care. No co-payment for immunizations and mammograms.	100% after a per visit co-payment of $15 for primary care and $20 for specialty care. No co-payment for immunizations and mammograms.

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Prescription Drugs • Generic • Preferred brand name • Non-preferred brand name Notes: Covers only prescriptions filled at participating local pharmacy or HMO medical center; mail order drug program for maintenance drugs sometimes offered.	100% after your per prescription co-payment • $10 • $20 • $35 Mail order: 90-day supply covered after two co-payments	100% after your per prescription co-payment • $10 • $20 • $35 Mail order: 90-day supply covered after two co-payments	100% after your per prescription co-payment At Kaiser pharmacy / At Eckerd's • $10 / • $16 • $20 / • $26 • Not applicable / • Not applicable Mail order: Up to 90-day supply; co-payment is per 30-day supply; add $1.50 for shipping fee per prescription	100% after your per prescription co-payment • $10 • $20 • $35 Mail order: 90-day supply covered after two co-payments
Maternity Treatment—Physician Services (pre-natal and post-natal)	100% after an initial co-payment of $20	100% after an initial co-payment of $20	100% after an initial co-payment of $20	100% after an initial co-payment of $20
Laboratory; X-Rays; Diagnostic Tests; Injections, including Medications Covered Under Medical Benefits—for the Treatment of an Illness or Injury	100%	100%	100%	100%
Allergy Shots and Serum	100% for shots and serum (if a physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20)	100% for shots and serum (if a physician is seen, visit is treated as an office visit subject to the lesser of the charge or the per visit co-payment of $20)	$5 for shots and $50 for six-month supply of serum	100% for shots and serum (if a physician is seen, visit is treated as an office visit subject to the per visit co-payment of $20)

Allergy Testing	100% after per visit co-payment of $20	100% after per visit co-payment of $20	100% after per visit co-payment of $20	100% after per visit co-payment of $20
Physician Services Furnished in a Hospital				
• Surgery in general, including charges by surgeon, anesthesiologist, pathologist, and radiologist	100%	100%	100%	100%
• Inpatient well-newborn exams	100%	100%	100%	100%
Physician Services That Are for Emergency Care	100% after applicable co-payment	100% after applicable co-payment	100% after applicable co-payment	100% after applicable co-payment
Outpatient Surgery in the physician's office	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery	100% after $20 co-payment if billed as office visit; 100% after $100 co-payment if billed as outpatient surgery
Outpatient Surgery—Hospital/Facility	100% after $100 per confinement co-payment	100% after $100 per confinement co-payment	100% after $100 per confinement co-payment	100% after $100 per confinement co-payment
Hospital Services Other Than Those That Are for Emergency Care				
• Inpatient care, including inpatient short-term acute rehabilitation services	100% after $200 per confinement co-payment	100% after $200 per confinement co-payment	100% after $200 per confinement co-payment	100% after $200 per confinement co-payment
• Outpatient services—Non-emergency use of emergency room	Requires prior authorization from PCP, otherwise not covered	Requires prior authorization from PCP, otherwise not covered	Requires prior authorization from PCP, otherwise not covered	Requires prior authorization from HMO, otherwise not covered
• Well-newborn care	100%	100%	100%	100%

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Hospital Services That Are for Emergency Care • Treatment of an emergency medical condition or injury	100% after a per visit co-payment of $50 (co-payment waived if admitted)	100% after a per visit co-payment of $50 (co-payment waived if admitted)	100% after a per visit co-payment of $50 (co-payment waived if admitted)	100% after a per visit co-payment of $50 (co-payment waived if admitted)
Ambulance Services for Emergency Care	100%	100%	100% after a $50 co-payment per trip when medically necessary	100%
Urgent Care Services in an Approved Urgent Care Center	100% after a $15 co-payment, referral required	100% after a $25 co-payment	100% after a $30 co-payment	100% after a $25 co-payment
Home Nursing Care	100%; up to 120 days per Plan year	100%; up to 120 days per Plan year	100%; up to 120 days per Plan year	100%; up to 120 days per Plan year
Hospice Care	100%; prior approval is required	100%; prior approval is required	100%; prior approval is required	100%; prior approval is required
Durable Medical Equipment (DME)—Rental or Purchase	100% when medically necessary	100% when medically necessary	100% when medically necessary	100% when medically necessary

Outpatient Acute Short-term Rehabilitation Services	100% after a $20 co-payment per visit; up to 40 visits per Plan year	100% after a $20 co-payment per visit; up to 40 visits per Plan year	100% after a $20 co-payment per visit; up to 40 visits per Plan year or up to two consecutive months per condition, whichever is more	100% after a $20 co-payment per visit; up to 40 visits per Plan year
Dental and Oral Care—Limited Coverage				
• Coverage in general	100% after applicable co-payment for oral surgery and dental services associated with an accidental injury to sound teeth	100% after applicable co-payment for oral surgery and dental services associated with an accidental injury to sound teeth	Services and appliances for accidental injury to sound and natural teeth: 50% coverage for first $1,000, then 100% thereafter	100% after applicable co-payment for oral surgery and dental services associated with an accidental injury to sound teeth
• Coverage of specific osseous surgeries for the treatment of periodontal disease	Not covered	Not covered	Not covered	Not covered
• Temporomandibular joint syndrome (TMJ)	100% after applicable co-payment, subject to limitations	100% after applicable co-payment, subject to limitations	50% for non-surgical treatment	100% after applicable co-payment, subject to limitations

HMO COVERED SERVICES

COVERED SERVICES	BLUECHOICE *The Plan Pays:*	CIGNA *The Plan Pays:*	KAISER PERMANENTE *The Plan Pays:*	UNITEDHEALTHCARE *The Plan Pays:*
Chiropractic Care	100% after $20 co-payment per visit; limited to 20 visits per Plan year	100% after $20 co-payment per visit; limited to 20 visits per Plan year	100% after $20 co-payment per visit; limited to 20 visits per Plan year	100% after $20 co-payment per visit; limited to 20 visits per Plan year
Behavioral Health Care (Mental health and substance abuse care)	For inpatient care: 100% after $50 co-payment per confinement; limited to 30 days per Plan year. For outpatient care: 100% after $20 co-payment per visit; limited to 25 visits per Plan year.	For inpatient care: 100% after $50 co-payment per confinement; limited to 30 days per Plan year. For outpatient care: 100% after $20 co-payment per visit; limited to 25 visits per Plan year.	Mental health: Inpatient services are covered at 100% after a $50 co-payment per admission; unlimited days. Outpatient services covered at 100% after $20 co-payment per visit; unlimited visits. Substance abuse: Inpatient services covered at 100% after a $50 co-payment per admission; up to 30 days per Plan year. Outpatient services covered at 100% after $20 co-payment per visit; up to 25 visits per Plan year. Detoxification: Co-payments same as above. No coverage limits on number of episodes, inpatient days, or outpatient visits.	For inpatient care: 100% after $50 co-payment per confinement; limited to 30 days per Plan year. For outpatient care: 100% after $20 co-payment per visit; limited to 25 visits per Plan year.
Transplant Services	100%	100%	100%	100%

IMPORTANT CONSIDERATIONS

- Annual dollar and visit limitations are based on a July 1 to June 30 Plan year.
- Some services may require prior authorization by the HMO before such services are covered. Also, some services may have limitations not contained in this summary.
- Most HMOs require the selection of a primary care physician (PCP) to manage your care. Failure to specify a PCP could delay receipt of your ID card. However, in some instances, the HMO assigns you a PCP located near your residence if a PCP is not specified.
  Note: UnitedHealthcare does not require the selection of a PCP.
- Most HMOs require you to obtain referrals to see most specialists. Failure to obtain a referral could result in a denial of your claim.
  Note: UnitedHealthcare does not require referrals for coverage of specialist services.
- Each HMO Option may offer vision care discounts or benefits. Contact the HMO directly for more information.
- Contact the HMO directly for more details regarding covered services, exclusions, and limitations.

Service Areas for Your Health Plan Options

Service Areas

Service areas are State-approved geographic areas, such as counties or zip codes, where providers participate in the network offered by the Plan option in which you have enrolled.

PPO and PPO Choice Option

Georgia Service Area

The Georgia service area includes the state of Georgia and the border communities of the Chattanooga, Tennessee area, including Bradley County; and Phenix City, Alabama. The zip code area in which you **receive a service** is used to determine whether or not you are in the Georgia service area. If you receive covered services from an MRN/Georgia 1st provider located in one of the zip codes below, you receive the highest level of coverage available in the PPO options.

Georgia:

All counties; all zip codes

Alabama:

Russell County (Phenix City area): 36851, 36856, 36858, 36859, 36860, 36867, 36868, 36869, 36870, 36871, and 36875.

Tennessee:

Bradley County (Cleveland area): 37310, 37311, 37312, 37320, 37323, 37353 and 37364.

Hamilton County (Chattanooga area): 37302, 37304, 37308, 37315, 37341, 37343, 37350, 37351, 37363, 37373, 37377, 37379, 37384, 37401, 37402, 37403, 37404, 37405, 37406, 37407, 37408, 37409, 37410, 37411, 37412, 37414, 37415, 37416, 37419, 37421, 37422, 37424, and 37450.

Out-of-State/National Service Area

The out-of-state service area includes all national locations outside of the Georgia service area described to the left. By using Beech Street providers outside of the Georgia service area, you are protected against being charged more than what the Plan allows. However, use of Beech Street providers inside the Georgia service area is considered out-of-network care with lower levels of coverage and separate deductibles, unless the provider also participates in the MRN/Georgia 1st network.

HMO Options

You must live or work in the HMO's approved service area to be eligible for coverage under that option. Below are the HMO Option service areas by county. If you live or work in a county marked "Yes" under any of the HMOs listed, you may enroll in that HMO. If the county where you live or work is not listed below, you are not eligible for HMO coverage.

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
Appling	Not Available	Yes	Not Available	Not Available
Bacon	Not Available	Yes	Not Available	Yes
Baldwin	Not Available	Yes	Not Available	Not Available
Banks	Yes	Not Available	Not Available	Yes
Barrow	Yes	Yes	Yes	Yes
Bartow	Yes	Yes	Yes	Yes
Ben Hill	Not Available	Not Available	Not Available	Yes
Berrien	Not Available	Not Available	Not Available	Yes
Bibb	Yes	Yes	Not Available	Yes
Bleckley	Yes	Yes	Not Available	Yes
Brooks	Not Available	Yes	Not Available	Yes
Bryan	Yes	Yes	Not Available	Yes
Bulloch	Yes	Yes	Not Available	Yes
Burke	Yes	Yes	Not Available	Yes
Butts	Yes	Yes	Yes	Yes
Candler	Not Available	Yes	Not Available	Yes
Carroll	Yes	Not Available	Not Available	Not Available
Catoosa	Not Available	Yes	Not Available	Not Available
Chatham	Yes	Yes	Not Available	Yes
Chattahoochee	Yes	Not Available	Not Available	Not Available
Chattooga	Yes	Yes	Not Available	Yes
Cherokee	Yes	Yes	Yes	Yes
Clarke	Yes	Yes	Not Available	Not Available
Clayton	Yes	Yes	Yes	Yes
Cobb	Yes	Yes	Yes	Yes
Colquitt	Not Available	Yes	Not Available	Yes
Columbia	Yes	Yes	Not Available	Yes
Coweta	Yes	Yes	Yes	Yes
Crawford	Yes	Not Available	Not Available	Yes
Dade	Not Available	Yes	Not Available	Not Available
Dawson	Yes	Not Available	Not Available	Yes
Decatur	Not Available	Yes	Not Available	Not Available
DeKalb	Yes	Yes	Yes	Yes

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
Dodge	Not Available	Yes	Not Available	Not Available
Douglas	Yes	Yes	Yes	Yes
Early	Not Available	Yes	Not Available	Yes
Effingham	Yes	Yes	Not Available	Yes
Elbert	Yes	Yes	Not Available	Not Available
Emanuel	Yes	Yes	Not Available	Yes
Evans	Not Available	Yes	Not Available	Yes
Fannin	Not Available	Yes	Not Available	Not Available
Fayette	Yes	Yes	Yes	Yes
Floyd	Yes	Yes	Not Available	Yes
Forsyth	Yes	Yes	Yes	Yes
Franklin	Yes	Yes	Not Available	Not Available
Fulton	Yes	Yes	Yes	Yes
Gilmer	Yes	Not Available	Not Available	Not Available
Glascock	Yes	Not Available	Not Available	Yes
Gordon	Yes	Yes	Not Available	Yes
Grady	Not Available	Yes	Not Available	Yes
Greene	Yes	Yes	Not Available	Yes
Gwinnett	Yes	Yes	Yes	Yes
Habersham	Not Available	Not Available	Not Available	Yes
Hall	Yes	Yes	Yes	Yes
Harris	Yes	Yes	Not Available	Not Available
Hart	Yes	Not Available	Not Available	Not Available
Heard	Yes	Not Available	Not Available	Not Available
Henry	Yes	Yes	Yes	Yes
Houston	Yes	Yes	Not Available	Yes
Jackson	Yes	Yes	Not Available	Yes
Jasper	Not Available	Not Available	Not Available	Yes
Jefferson	Yes	Yes	Not Available	Yes
Jenkins	Yes	Not Available	Not Available	Yes
Johnson	Yes	Not Available	Not Available	Not Available
Jones	Yes	Yes	Not Available	Yes
Lamar	Not Available	Not Available	Not Available	Yes
Lanier	Not Available	Not Available	Not Available	Yes
Laurens	Not Available	Yes	Not Available	Not Available
Liberty	Yes	Yes	Not Available	Yes
Lincoln	Yes	Yes	Not Available	Yes

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
Long	Not Available	Yes	Not Available	Yes
Lowndes	Not Available	Yes	Not Available	Yes
Lumpkin	Yes	Not Available	Not Available	Yes
Madison	Yes	Yes	Not Available	Not Available
Marion	Yes	Yes	Not Available	Not Available
McDuffie	Yes	Yes	Not Available	Yes
Meriwether	Yes	Not Available	Not Available	Yes
Mitchell	Not Available	Yes	Not Available	Yes
Monroe	Yes	Not Available	Not Available	Yes
Morgan	Yes	Not Available	Not Available	Yes
Muscogee	Yes	Yes	Not Available	Not Available
Newton	Yes	Yes	Yes	Yes
Oconee	Yes	Yes	Not Available	Not Available
Oglethorpe	Yes	Yes	Not Available	Not Available
Paulding	Yes	Yes	Yes	Yes
Peach	Yes	Yes	Not Available	Yes
Pickens	Yes	Not Available	Not Available	Yes
Pike	Not Available	Not Available	Not Available	Yes
Polk	Yes	Yes	Not Available	Yes
Pulaski	Yes	Yes	Not Available	Yes
Putnam	Not Available	Not Available	Not Available	Yes
Richmond	Yes	Yes	Not Available	Yes
Rockdale	Yes	Yes	Yes	Yes
Screven	Not Available	Yes	Not Available	Yes
Seminole	Not Available	Yes	Not Available	Yes
Spalding	Yes	Yes	Yes	Yes
Stewart	Yes	Not Available	Not Available	Not Available
Sumter	Not Available	Yes	Not Available	Not Available
Talbot	Yes	Not Available	Not Available	Not Available
Taliaferro	Not Available	Not Available	Not Available	Yes
Tattnall	Not Available	Yes	Not Available	Yes
Taylor	Not Available	Yes	Not Available	Not Available
Thomas	Not Available	Yes	Not Available	Yes
Tift	Not Available	Not Available	Not Available	Yes
Toombs	Not Available	Yes	Not Available	Yes
Twiggs	Yes	Not Available	Not Available	Yes
Upson	Not Available	Yes	Not Available	Not Available

County of Residence	BlueChoice	CIGNA	Kaiser Permanente	UnitedHealthcare
Walker	Not Available	Yes	Not Available	Not Available
Walton	Yes	Yes	Yes	Yes
Ware	Not Available	Not Available	Not Available	Yes
Warren	Yes	Not Available	Not Available	Yes
Washington	Yes	Not Available	Not Available	Not Available
Wayne	Not Available	Not Available	Not Available	Yes
White	Yes	Not Available	Not Available	Yes
Whitfield	Not Available	Yes	Not Available	Not Available
Wilkes	Yes	Yes	Not Available	Yes
Wilkinson	Yes	Yes	Not Available	Not Available
Worth	Not Available	Not Available	Not Available	Yes

Health Insurance Portability and Accountability Act (HIPAA) Annual Notice

This section describes certain rights available to you under the Health Insurance Portability and Accountability Act (HIPAA) when you enroll in the SHBP.

The PPO and Indemnity Options contain a pre-existing condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over $1,000 for the treatment of any pre-existing condition during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment or medication for that condition for at least six consecutive calendar months. If you are enrolling as a new hire, this 12-month period begins on your hire date. However, a pre-existing condition limitation does not apply to coverage for:

- Pregnancy; or
- Newborns or children under age 18 who are adopted or placed for adoption, if the child becomes covered within 31 days after birth, adoption, or placement for adoption.

In certain situations, SHBP members and dependents can reduce the 12-month pre-existing condition limitation period. The reduction is possible by using what is called "creditable coverage" to offset a pre-existing condition period. Creditable coverage generally includes the health coverage you or a family member had immediately prior to joining the SHBP. Coverage under most group health plans, as well as coverage under individual health policies and governmental health programs, qualifies as creditable coverage.

To reduce the pre-existing condition limitation period for your own coverage, you must provide the SHBP with a certificate of creditable coverage from one or more former health plans or insurers that states when your prior coverage started and ended. Any period of prior coverage will reduce the 12-month limitation period if the time between losing coverage and your first day of SHBP coverage does not exceed 63 days. If you are enrolling as a new hire, the 63-day period is measured from your last day of prior coverage up to your date of hire.

To reduce the pre-existing condition limitation period for your dependents (including your spouse), you must provide the SHBP with a certificate of creditable coverage stating when coverage started and ended for each dependent that you want to cover. Again, any period of prior coverage for that dependent will reduce the 12-month limitation period if no more than 63 days have elapsed between the dependent's loss of prior coverage and the first day of coverage under the SHBP (or your date of hire, if you are enrolling as a new hire).

If you or a dependent (including a spouse) had any break in coverage lasting more than 63 days, you or your dependent will receive creditable coverage only for the period of time after the break ended.

Within two years after your former coverage terminated, you have the right to obtain a letter of creditable coverage from your former employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate your certificate of coverage or other documentation to determine whether any of the pre-existing condition limitation period will be reduced or eliminated. After completing the evaluation, the SHBP will notify you as to how the pre-existing condition limitation period will be reduced or eliminated. You have the right to appeal any decision related to a prior creditable coverage determination.

Please submit your letter of creditable coverage to the Plan with your enrollment paperwork. If you require assistance in obtaining a letter from a former employer, contact your personnel/payroll office.

Women's Health and Cancer Rights Act of 1998

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option.

Following cancer surgery, the SHBP covers:

- Reconstruction of the breast on which the mastectomy has been performed;
- Reconstruction of the other breast to achieve a symmetrical appearance;
- Prostheses and mastectomy bras; and
- Treatment of physical complications at any stage of the mastectomy, including lymphedemas.

Note: Reconstructive surgery requires prior approval and all inpatient admissions require MCP precertification.

For more detailed information on the mastectomy-related benefits available under the Plan, you can contact the Member Services unit for your coverage option. Telephone numbers are on the inside front cover.

Penalties for Misrepresentation

If any SHBP participant misrepresents the facts when applying for coverage, change of coverage, or benefits, the SHBP may terminate the person's participation (and that of his or her dependents) and seek legal recovery of any money paid out by the SHBP as a result of the misrepresentation.

Disclaimer

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of Plan or program benefits and does not constitute a contract or any part of one. For a complete description of the benefits available to you, including procedures, exclusions, and limitations, refer to your specific Plan documents, which may include the State Health Benefit Plan Summary Plan Description, Summary of Material Modification (UPDATER), Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy, and any applicable riders to your Plan. All the terms and conditions of your Plan or program are subject to and governed by applicable contracts, laws, regulations, and policies. Certain services, including but not limited to non-emergency inpatient hospital care, require precertification. All benefits are subject to coordination of benefits unless noted otherwise. In case of a conflict between your Plan documents and this information, the Plan documents will govern.